TRACKING FORM 4 MONTHS

TO BE FILLED IN BY OFFICE STAFF:							
Last Name First Name			AHCCCS ID		D.O.B.	Age	
						1 -0-	
Primary Care Prov	vider		Date of Examination		Health Plan Name	Health Plan Name	
Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile Percentile	
	TO BE FILLED IN BY PROVIDER						
HISTORY INIT	ITIAL/INTERVAL					Т	
Comments							
NUTRITIONAL ASSESSMENT [] Breast Feeding [] Formula (type)						P	
Supplements: [] Fluoride [] Vitamins [] Iron [] Solids SENSORY ASSESSMENT Vision: Within normal limits? [] Yes [] No, Refer						R	
	Hearing: Within normal limits? [] Yes [] No. Refer						
Babbles and coos, when prone-holds head erect and raises body on hands, rolls over from prone to supine, grasps rattle,							
controls head well (If suspicious, do specific objective testing) Assessment Tool (name)							
PHYSICAL EXAM COMMENTS, ASSESSMENT & PLAN							
Are the following normal?							
Skin	Yes	No					
Head							
Eyes (red reflex))						
Ears							
Nose	***************************************						
Mouth/Throat							
Nodes							
Heart	***************************************						
Lungs	UHAHHIAAA						
Fern. Pulse							
Ext. Gen.							
Hlp Abduc.	The state of the s						
Extremities							
Spine	IND.						
Neuro		Follow-up needed	d?		[] Y e	es [] No	
Other			N ASSESSMENT		t 1 *-	3 [] 140	
LAB/SCREENIN	NG		ceive all immuniz		ウ [] V:	o r i Nio	
Hct./Hgb.			t immunization re				
ANTICIPATORY GUIDANCE REFER					ERRALS		
[] Injury prevention [] Sleep			tioning	1 1	CRS		
[] Choking, as [] Teething	spiration	[] Thumb suc		()	WIC		
[] Solid foods	i	[] Baby-proof [] Appropriat	r nome te child care provi		Specialty		
		THE PROPERTY OF THE PROPERTY O	_		A ABUAT		
Next scheduled vis	sit	Clinician Name		Clini	ician Signature		
Was this claim coded as an EPSDT Visit (HCFA-1500)? [] Yes [] No							